SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Filing at a Glance

Company: Kansas City Life Insurance Company

Product Name: R223	SERFF Tr Num: KCLF-127814876	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 50335
Sub-TOI: L08.000 Life - Other	Co Tr Num: R223	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Kathleen Frese	Disposition Date: 11/30/2011
	Date Submitted: 11/23/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: R223	Status of Filing in Domicile: Pending
Project Number: R223	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 11/30/2011
	State Status Changed: 11/30/2011
Deemer Date:	Created By: Kathleen Frese
Submitted By: Kathleen Frese	Corresponding Filing Tracking Number:

Filing Description:

The Enhanced Living Benefits Rider will be issued with our Universal Life and Variable Universal Life products on the lives of Insureds at their request. There is only one minor difference between R223 and R224. R223 uses the word “Contract”, whereas R224 uses the word “Policy”. We created separate rider forms to consistently refer to our Variable Universal Life plans (where we use the term ‘contract’) and our Universal Life plans (where we use the term ‘policy’). These riders provide the Insured with the ability to accelerate an amount up to the benefit base which is 90% of the policy’s specified amount, in either monthly payments or a lump sum, if the Insured qualifies for benefits under either the Chronic Condition Option or the Confinement Option.

Enclosed are forms M686 and M687, “How the Enhanced Living Benefits Rider Works.” This disclosure will be presented to the client at the time of application and requires the signature of the client and agent. One copy will be left

with the client and the other copy will be sent to the Home Office. We also included example data pages to show where this rider would be incorporated into the policy or contract.

Also enclosed is Form A165 is the Supplement to Application for the Enhanced Living Benefits Rider. This will be used when the client is applying for the rider.

Company and Contact

Filing Contact Information

Kathleen Frese, Compliance Analyst III	kfrese@kclife.com
3520 Broadway	816-753-7299 [Phone] 8283 [Ext]
Kansas City, MO 64111	816-753-3018 [FAX]

Filing Company Information

Kansas City Life Insurance Company	CoCode: 65129	State of Domicile: Missouri
P O Box 219139	Group Code: 588	Company Type: Life
Kansas City, MO 64121-9139	Group Name:	State ID Number:
(800) 821-5529 ext. [Phone]	FEIN Number: 44-0308260	

Filing Fees

Fee Required?	Yes
Fee Amount:	$150.00
Retaliatory?	No
Fee Explanation:	3 forms times $50 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Kansas City Life Insurance Company	$150.00	11/23/2011	54040439

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	11/30/2011	11/30/2011

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Disposition

Disposition Date: 11/30/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Disclosures		Yes
Supporting Document	Sample Schedule Page		Yes
Supporting Document	Actuarial Memorandum		No
Supporting Document	Statement of Variability		Yes
Form	Enhanced Living Benefits Rider		Yes
Form	Enhanced Living Benefits Rider		Yes
Form	Enhanced Living Benefits Rider Supplement to Application		Yes

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Form Schedule

Lead Form Number: R223

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	R223	Certificate Amendment, Insert Page, Endorsement or Rider	Enhanced Living Benefits Rider	Initial		50.400	R223.pdf
	R224	Certificate Amendment, Insert Page, Endorsement or Rider	Enhanced Living Benefits Rider	Initial		50.400	R224.pdf
	A165	Application/ Enrollment Form	Enhanced Living Benefits Rider Supplement to Application	Initial		60.800	A165.pdf

KANSAS CITY LIFE
INSURANCE COMPANY

Enhanced Living Benefits Rider

THIS RIDER PROVIDES FOR PAYMENT OF A PORTION OF THE CONTRACT DEATH PROCEEDS PRIOR TO THE DEATH OF THE INSURED UNDER CONDITIONS EXPLAINED IN THIS RIDER.

CONTRACT VALUES AND DEATH BENEFITS ARE REDUCED WHEN ACCELERATED BENEFITS ARE PAID UNDER THIS RIDER. RECEIPT OF ACCELERATED DEATH BENEFITS MAY ADVERSELY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID) OR OTHER GOVERNMENT BENEFITS. THE ACCELERATED BENEFIT UNDER THIS RIDER MAY BE TAXABLE. AS WITH ALL TAXABLE MATTERS, YOU SHOULD DISCUSS THIS WITH YOUR TAX ADVISOR TO DETERMINE THE TAX CONSEQUENCES PRIOR TO ELECTING TO RECEIVE THE BENEFITS.

THIS RIDER DOES NOT PROVIDE HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE. THERE ARE NO RESTRICTIONS OR LIMITS ON THE USE OF ACCELERATED BENEFIT PAYMENTS.

Definitions

The following are key words used in this rider. As you read this rider, refer to these definitions.

Activities of Daily Living
Activities of Daily Living are:

1. Bathing - Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.
2. Continence - The ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
5. Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring - Moving into or out of a bed, chair or wheelchair.

Benefit Base
The Benefit Base is used in the calculation of your benefit under this rider and is shown in Section 1, Contract Data.

The Benefit Base cannot ever exceed the lesser of [90%] of the specified amount of the Contract and $[500,000]. Reductions in the Contract's specified amount may cause a reduction in the Benefit Base.

Automatic, periodic increases in the Contract's specified amount as provided by riders, such as the Cost of Living Rider, will increase the Benefit Base by the same percentage as the increase in the specified amount, subject to the Benefit Base limitations described in this section.

Chronic Condition
The Insured has currently, and has been certified by a Licensed Physician within the last 12 months as having, a condition resulting in:

1. being permanently unable to perform, without substantial assistance from another individual, at least two Activities of Daily Living due to a loss of functional capacity; or
2. requiring substantial supervision to protect such Insured from threats to health and safety due to permanent Severe Cognitive Impairment.

To qualify as a Chronic Condition, the Insured must be receiving Health Care Assistance as defined herein at least two times per week.

Confined or Confinement
The Insured must be residing in and receiving care in an Eligible Nursing Home as defined herein.

Eligible Nursing Home
An institution or special nursing unit of a hospital that meets at least one of the following requirements:

1. approved as a Medicare provider of skilled nursing care services; or
2. licensed as a skilled nursing home or as an intermediate care facility by the state in which it is located; or
3. meets all the requirements listed below:
    a. licensed as a nursing home by the state in which it is located;
    b. main function is to provide skilled or intermediate nursing care;
    c. engaged in providing continuous room and board accommodations to 3 or more persons;
    d. under the supervision of a registered nurse (RN) or licensed practical nurse (LPN);
    e. maintains a daily medical record of each patient; and
    f. maintains control and records for all medications dispensed.

Institutions that primarily provide residential facilities do not qualify as Eligible Nursing Homes.

Health Care Assistance
Services to assist the insured in Activities of Daily Living or required because of Cognitive Impairment. Health Care Assistance must be received in the United States. Health Care Assistance is not limited by location; it may be received where appropriate including but not limited to the insured's residence (permanent or temporary), a hospital, a nursing home, a hospice center, assisted living facility, or any other care facility. Health Care Assistance must be:

1. received from a Health Care Provider as defined herein, and
2. be documented per a current Plan of Care as defined herein.

Health Care Provider
Health Care Providers must be trained to provide the type of care given. Health Care Providers may be representatives of Home Health Agencies, independent home health care providers, home health aides, therapists, or other health care professionals. A Health Care Provider cannot be a member of the Insured's Immediate Family.

Immediate Family
The Insured or the Insured's spouse, or the following relatives of the Insured or the Insured's spouse: parents, grandparents, stepparents, siblings, children, stepchildren, grandchildren, and their respective spouses.

Licensed Physician
A licensed Doctor of Medicine (M.D.) or licensed Doctor of Osteopathy (D.O.) operating within the scope of licensure. This does not include the Insured or a member of the Insured's Immediate Family.

Plan of Care
A written plan for services designed especially for the Insured. This Plan of Care must specify the type, frequency and providers of all the services the Insured requires. The Plan of Care must be approved by a physician, registered nurse (R.N.), licensed social worker or any other individual who meets the requirements of a licensed health care practitioner as may be prescribed by the U.S. Secretary of the Treasury. The person approving the Plan of Care may not be a member of the Insured's Immediate Family.

Severe Cognitive Impairment
The deterioration or loss of the Insured's intellectual capacity, which requires substantial supervision by another person to protect the Insured or others. It is measured by clinical evidence and standardized tests which reliably measure the Insured's impairment in:

1. short or long term memory;
2. orientation as to people, places or time; and
3. deductive or abstract reasoning.

Severe cognitive impairment includes conditions such as Alzheimer's disease and similar forms of irreversible dementia.

Substantial Assistance
This means hands-on assistance or standby assistance. Hands-on assistance means the physical assistance of another person without which the Insured would be unable to perform the Activity of Daily Living. Standby assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing an Activity of Daily Living.

Benefits Under This Rider

The Benefit
We will provide the opportunity for you to receive monthly benefits or a lump sum benefit prior to the death of the Insured. This rider provides two options under which the Insured may qualify for benefits:

1. Chronic Condition Option; and
2. Confinement Option.

You may elect payments under both options. We describe these options and the payments in more detail below.

Maximum Accelerated Benefit Amount
In no case will any combination of benefits paid for Chronic Condition or Confinement exceed the Maximum Accelerated Benefit Amount, shown in Section 1, Contract Data. The total accelerated death benefits payable under all contracts, policies, or riders on the life of a single insured can never exceed $[500,000] regardless of the number or sizes of the contracts, policies, or riders in force.

Additionally the maximum monthly benefit amount may not exceed the per diem limitation described in section 7702B(d) of the Internal Revenue Code.

Monthly Benefit
The monthly benefit amounts will be determined as follows:

Monthly Chronic Condition Benefit
The maximum amount of the monthly chronic condition benefit is shown in Section 1, Contract Data, payable up to the Maximum Accelerated Benefit Amount.

Monthly Confinement Benefit
The maximum amount of the monthly confinement benefit is shown in Section 1, Contract Data, payable up to the Maximum Accelerated Benefit Amount.

You may elect to receive an amount less than the amounts available for the monthly chronic condition benefit and the monthly confinement benefit. However, we reserve the right to require that each monthly payment be a minimum of $50.

If the benefits are payable for a period of less than one month, the amount payable for each day will be $1/30^{th}$ of the monthly benefit.

If the Contract has an outstanding loan balance, we will deduct a portion of the monthly benefit payment and apply this portion to reduce the loan balance.

The portion deducted will equal:

$$\frac{(A \times B)}{C}$$

"A" is the monthly benefit payment.

"B" is the greater of the outstanding loan balance on the date of the monthly benefit payment or the largest previous outstanding loan balance on any previous date of a monthly benefit payment.

"C" is the specified amount of the Contract.

The amount deducted from the monthly benefit to be applied to the loan is considered part of the monthly benefit.

Lump Sum Benefit
A lump sum benefit is offered in lieu of monthly payments. If a lump sum benefit is elected, no monthly benefits or future lump sum benefits under the corresponding option are available in the future. Similarly, if monthly payments are elected a lump sum payment for the corresponding option is not available in the future.

The lump sum benefit amounts will be determined as follows:

Lump Sum Chronic Condition Benefit
The maximum amount of the lump sum chronic condition benefit is shown in Section 1, Contract Data and cannot be more than the Maximum Accelerated Benefit Amount.

Lump Sum Confinement Benefit
The maximum amount of the lump sum confinement benefit is shown in Section 1, Contract Data and cannot be more than the Maximum Accelerated Benefit Amount.

You may elect to receive an amount less than the amounts available for the lump sum chronic condition benefit and the lump sum confinement benefit. However, we reserve the right to require that the payment be a minimum of $500.

If the Contract has an outstanding loan balance, we will deduct a portion of the lump sum benefit payment and apply this portion to reduce the loan balance. The portion deducted will equal:

$$\frac{(A \times B)}{C}$$

"A" is the lump sum benefit payment.

"B" is the value of the outstanding loan balance on the date of the lump sum benefit payment.

"C" is the specified amount of the Contract.

The amount deducted from the lump sum to be applied to the loan is considered part of the lump sum benefit.

Chronic Condition Option
If the Insured has a chronic condition, you may elect this option to provide monthly chronic condition benefits. In order to exercise this option:

1. we must receive evidence satisfactory to us that the Insured has a chronic condition, and
2. the Insured must have had the chronic condition continuously for the preceding 90 days.

If you do not wish to receive monthly payments, you may elect to receive a lump sum as described above.

Confinement Option
If the Insured is confined, you may elect this option to provide monthly confinement benefits. In order to exercise this option:

1. the Insured must be currently, and have been continuously for the preceding 90 days, confined as defined herein, and
2. the Insured's confinement must be due to medical reasons that are verified by a licensed physician.

If you do not wish to receive monthly payments, you may elect to receive a lump sum as described above.

Conditions
Your right to receive payment under either option is subject to the following conditions:

1. You must elect an option in writing and provide initial and ongoing evidence of qualification in a form that meets our requirements;
2. The Contract must be in force and not be in the grace period;
3. We must receive the approval of any assignee or irrevocable beneficiary under your Contract;
4. We have the right to seek a second medical opinion as to a Chronic Condition the Insured may have or the medical necessity for nursing home confinement. If we seek a second medical opinion, we will pay for it and will base eligibility for benefits on that opinion;
5. This benefit provides for the accelerated payment of life insurance proceeds and is not intended to cause you to involuntarily gain access to proceeds ultimately payable to the named beneficiary. Therefore, we will make the accelerated death benefit proceeds available to you on a voluntary basis only. Accordingly:
    a. if you are required by law to exercise this option to satisfy the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit; or
    b. if you are required by a government agency to exercise this option in order to apply for, obtain, or retain a government benefit or entitlement, you are not eligible for this benefit.

Effect on Contract
Payments under this rider will reduce the amount payable on death, maturity or surrender of the Contract.

We will deduct the lien from values available for withdrawal or loan.

If the death benefit option on your Contract is Option B or Option C when benefits become payable, we will automatically change the death benefit option to Option A. The new Option A specified amount will be the specified amount as described in the Contract's option change provision. The Benefit Base will be increased in proportion to the increase in the specified amount, but cannot exceed the Maximum Accelerated Benefit Amount shown in Section 1, Contract Data.

After any benefit payment is made under this rider we will have an absolute first lien against the Contract for an amount equal to the sum of all benefits paid under this rider.

We will exercise the lien when:

1. benefit payments are no longer payable under this rider;
2. you have received benefit payments totaling the Maximum Accelerated Benefit Amount;
3. the Contract terminates for any reason; or
4. this rider terminates for any reason.

On the date the lien is exercised, the values in the Contract are adjusted as follows:

1. the specified amount is reduced by the amount of the lien;
2. the Contract Value is reduced by an amount equal to the lien multiplied by the ratio of the Contract value to the specified amount of the Contract;
3. the Benefit Base is reduced by the amount of the lien; and
4. surrender charges are reduced in proportion to the reduction in the specified amount.

After the lien is exercised there will be no further lien against the Contract. When the lien is exercised while the Contract is in force, we will send you updated information reflecting the changes to the values in the Contract.

Rider Cost of Insurance

The cost of insurance for this rider is determined on a monthly basis. The cost of insurance rates for this rider will not exceed the rates shown in the Table of Guaranteed Maximum Monthly Enhanced Living Benefits Cost of Insurance Rates per $1,000, found on the last page of this rider. The cost of insurance rate multiplied by the Benefit Base divided by the specified amount of the Contract is added to the Insured's cost of insurance rate for the Contract. The

cost of insurance is then determined as provided in the Contract using the increased rates.

The cost of insurance for this rider will be deducted monthly from the Contract value.

General Provisions

The following provisions apply to this rider:

Applicability
This rider is a part of the Contract to which it is attached, and this benefit is subject to all the provisions of this rider and the applicable Contract provisions.

Effective Date
The effective date of this rider is shown in Section 1, Contract Data. The incontestability provision in the Contract will apply to this rider, beginning on the rider effective date.

Cancellation
We may not cancel or reduce coverage under this rider. You may cancel this rider on any monthly anniversary day. Your request must be in writing and filed with us prior to the monthly anniversary day.

Conformity with State Statutes
On the effective date of this rider, if any provisions are in conflict with the laws of the state in which you reside, then these provisions are amended to conform to the minimum requirements of such laws.

Termination of Rider
This rider terminates on the earliest of:

1. the date the Contract terminates for any reason;
2. the date this rider is cancelled by you;
3. the date you have received benefit payments totaling the Maximum Accelerated Benefit Amount;
4. the date the Contract matures;
5. the date you exercise a Paid-up Insurance Benefit option, if any, in the Contract; or
6. the date no further benefit payments are available under either option.

Table of Guaranteed Maximum Monthly Enhanced Living Benefits Cost of Insurance Rates per $1,000

Age	Male	Female	Age	Male	Female	Age	Male	Female
0	0.06000	0.06583	34	0.07000	0.08750	68	0.79083	0.82667
1	0.04667	0.05917	35	0.07167	0.09000	69	0.87917	0.90500
2	0.04500	0.05667	36	0.07500	0.09500	70	0.96583	0.98917
3	0.04417	0.05500	37	0.07833	0.09917	71	1.06417	1.08000
4	0.04167	0.05417	38	0.08250	0.10417	72	1.17667	1.17917
5	0.04000	0.05250	39	0.08833	0.10917	73	1.28500	1.29167
6	0.03750	0.05083	40	0.09417	0.11583	74	1.39917	1.44500
7	0.03500	0.05000	41	0.10083	0.12167	75	1.51833	1.63667
8	0.03417	0.04917	42	0.10917	0.12750	76	1.69167	1.84917
9	0.03333	0.04833	43	0.11750	0.13333	77	1.87417	2.07750
10	0.03417	0.04833	44	0.12667	0.13750	78	2.08333	2.32583
11	0.03667	0.04917	45	0.13667	0.14500	79	2.26167	2.57167
12	0.04167	0.05167	46	0.14750	0.15333	80	2.45833	2.80917
13	0.04833	0.05417	47	0.15833	0.16250	81	2.67667	3.11083
14	0.05667	0.05833	48	0.17000	0.17417	82	2.92250	3.43667
15	0.05750	0.06083	49	0.18250	0.18583	83	3.17083	3.73250
16	0.05833	0.06333	50	0.19583	0.19917	84	3.43333	4.04333
17	0.06000	0.06583	51	0.20917	0.21250	85	3.70333	4.42167
18	0.06083	0.06583	52	0.22333	0.22667	86	4.00583	4.81167
19	0.06167	0.06667	53	0.23667	0.24167	87	4.31083	5.21333
20	0.06250	0.06750	54	0.25250	0.25583	88	4.61667	5.70417
21	0.06250	0.06833	55	0.27000	0.27167	89	4.92667	6.22250
22	0.06250	0.06917	56	0.28833	0.28833	90	5.24667	6.77083
23	0.06250	0.07083	57	0.30667	0.30750	91	5.58500	7.36250
24	0.06250	0.07250	58	0.32583	0.32833	92	5.95417	8.02083
25	0.06250	0.07417	59	0.34583	0.35417	93	6.39667	8.79500
26	0.06333	0.07583	60	0.36833	0.38250	94	6.99667	9.79833
27	0.06417	0.07667	61	0.39167	0.41667	95	7.59667	10.80583
28	0.06500	0.07833	62	0.43167	0.45583	96	8.19667	11.82167
29	0.06500	0.08000	63	0.47667	0.50250	97	8.79667	12.85000
30	0.06583	0.08167	64	0.52667	0.55500	98	9.39667	13.90333
31	0.06583	0.08250	65	0.58083	0.61500	99+	10.00000	15.00000
32	0.06667	0.08417	66	0.64833	0.68000			
33	0.06750	0.08500	67	0.72250	0.75167			

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO BOX 219139, Kansas City, MO 64121-9139.

Secretary

President, CEO and Chairman

KANSAS CITY LIFE
INSURANCE COMPANY

Enhanced Living Benefits Rider

THIS RIDER PROVIDES FOR PAYMENT OF A PORTION OF THE POLICY DEATH PROCEEDS PRIOR TO THE DEATH OF THE INSURED UNDER CONDITIONS EXPLAINED IN THIS RIDER.

POLICY ACCUMULATED VALUES AND DEATH BENEFITS ARE REDUCED WHEN ACCELERATED BENEFITS ARE PAID UNDER THIS RIDER. RECEIPT OF ACCELERATED DEATH BENEFITS MAY ADVERSELY AFFECT ELIGIBILITY FOR PUBLIC ASSISTANCE PROGRAMS SUCH AS MEDICAL ASSISTANCE (MEDICAID) OR OTHER GOVERNMENT BENEFITS. THE ACCELERATED BENEFIT UNDER THIS RIDER MAY BE TAXABLE. AS WITH ALL TAXABLE MATTERS, YOU SHOULD DISCUSS THIS WITH YOUR TAX ADVISOR TO DETERMINE THE TAX CONSEQUENCES PRIOR TO ELECTING TO RECEIVE THE BENEFITS.

THIS RIDER DOES NOT PROVIDE HEALTH, NURSING HOME, OR LONG TERM CARE INSURANCE. THERE ARE NO RESTRICTIONS OR LIMITS ON THE USE OF ACCELERATED BENEFIT PAYMENTS.

Definitions

The following are key words used in this rider. As you read this rider, refer to these definitions.

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2. Continence - The ability to maintain control of bowel and bladder function; or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).
3. Dressing - Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. Eating - Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
5. Toileting - Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. Transferring - Moving into or out of a bed, chair or wheelchair.

Benefit Base
The Benefit Base is used in the calculation of your benefit under this rider and is shown in Section 1, Policy Data.

The Benefit Base cannot ever exceed the lesser of [90%] of the specified amount of the Policy and $[500,000]. Reductions in the Policy's specified amount may cause a reduction in the Benefit Base.

Automatic, periodic increases in the Policy's specified amount as provided by riders, such as the Cost of Living Rider, will increase the Benefit Base by the same percentage as the increase in the specified amount, subject to the Benefit Base limitations described in this section.

Chronic Condition
The Insured has currently, and has been certified by a Licensed Physician within the last 12 months as having, a condition resulting in:

1. being permanently unable to perform, without substantial assistance from another individual, at least two Activities of Daily Living due to a loss of functional capacity; or
2. requiring substantial supervision to protect such Insured from threats to health and safety due to permanent Severe Cognitive Impairment.

To qualify as a Chronic Condition, the Insured must be receiving Health Care Assistance as defined herein at least two times per week.

Confined or Confinement
The Insured must be residing in and receiving care in an Eligible Nursing Home as defined herein.

Eligible Nursing Home
An institution or special nursing unit of a hospital that meets at least one of the following requirements:

1. approved as a Medicare provider of skilled nursing care services; or
2. licensed as a skilled nursing home or as an intermediate care facility by the state in which it is located; or
3. meets all the requirements listed below:
    a. licensed as a nursing home by the state in which it is located;
    b. main function is to provide skilled or intermediate nursing care;
    c. engaged in providing continuous room and board accommodations to 3 or more persons;
    d. under the supervision of a registered nurse (RN) or licensed practical nurse (LPN);
    e. maintains a daily medical record of each patient; and
    f. maintains control and records for all medications dispensed.

Institutions that primarily provide residential facilities do not qualify as Eligible Nursing Homes.

Health Care Assistance
Services to assist the insured in Activities of Daily Living or required because of Cognitive Impairment. Health Care Assistance must be received in the United States. Health Care Assistance is not limited by location; it may be received where appropriate including but not limited to the insured's residence (permanent or temporary), a hospital, a nursing home, a hospice center, assisted living facility, or any other care facility. Health Care Assistance must be:

1. received from a Health Care Provider as defined herein, and
2. be documented per a current Plan of Care as defined herein.

Health Care Provider
Health Care Providers must be trained to provide the type of care given. Health Care Providers may be representatives of Home Health Agencies, independent home health care providers, home health aides, therapists, or other health care professionals. A Health Care Provider cannot be a member of the Insured's Immediate Family.

Immediate Family
The Insured or the Insured's spouse, or the following relatives of the Insured or the Insured's spouse: parents, grandparents, stepparents, siblings, children, stepchildren, grandchildren, and their respective spouses.

Licensed Physician
A licensed Doctor of Medicine (M.D.) or licensed Doctor of Osteopathy (D.O.) operating within the scope of licensure. This does not include the Insured or a member of the Insured's Immediate Family.

Plan of Care
A written plan for services designed especially for the Insured. This Plan of Care must specify the type, frequency and providers of all the services the Insured requires. The Plan of Care must be approved by a physician, registered nurse (R.N.), licensed social worker or any other individual who meets the requirements of a licensed health care practitioner as may be prescribed by the U.S. Secretary of the Treasury. The person approving the Plan of Care may not be a member of the Insured's Immediate Family.

Severe Cognitive Impairment
The deterioration or loss of the Insured's intellectual capacity, which requires substantial supervision by another person to protect the Insured or others. It is measured by clinical evidence and standardized tests which reliably measure the Insured's impairment in:

1. short or long term memory;
2. orientation as to people, places or time; and
3. deductive or abstract reasoning.

Severe cognitive impairment includes conditions such as Alzheimer's disease and similar forms of irreversible dementia.

Substantial Assistance
This means hands-on assistance or standby assistance. Hands-on assistance means the physical assistance of another person without which the Insured would be unable to perform the Activity of Daily Living. Standby assistance means the presence of another person within arm's reach of the Insured that is necessary to prevent, by physical intervention, injury to the Insured while he or she is performing an Activity of Daily Living.

Benefits Under This Rider

The Benefit
We will provide the opportunity for you to receive monthly benefits or a lump sum benefit prior to the death of the Insured. This rider provides two options under which the Insured may qualify for benefits:

1. Chronic Condition Option; and
2. Confinement Option.

You may elect payments under both options. We describe these options and the payments in more detail below.

Maximum Accelerated Benefit Amount
In no case will any combination of benefits paid for Chronic Condition or Confinement exceed the Maximum Accelerated Benefit Amount, shown in Section 1, Policy Data. The total accelerated death benefits payable under all policies, contracts, or riders on the life of a single insured can never exceed $[500,000] regardless of the number or sizes of the contracts, policies, or riders in force.

Additionally the maximum monthly benefit amount may not exceed the per diem limitation described in section 7702B(d) of the Internal Revenue Code.

Monthly Benefit
The monthly benefit amounts will be determined as follows:

Monthly Chronic Condition Benefit
The maximum amount of the monthly chronic condition benefit is shown in Section 1, Policy Data, payable up to the Maximum Accelerated Benefit Amount.

Monthly Confinement Benefit
The maximum amount of the monthly confinement benefit is shown in Section 1, Policy Data, payable up to the Maximum Accelerated Benefit Amount.

You may elect to receive an amount less than the amounts available for the monthly chronic condition benefit and the monthly confinement benefit. However, we reserve the right to require that each monthly payment be a minimum of $50.

If the benefits are payable for a period of less than one month, the amount payable for each day will be $1/30^{th}$ of the monthly benefit.

If the Policy has an outstanding loan balance, we will deduct a portion of the monthly benefit payment and apply this portion to reduce the loan balance.

The portion deducted will equal:

$$\frac{(A \times B)}{C}$$

"A" is the monthly benefit payment.

"B" is the greater of the outstanding loan balance on the date of the monthly benefit payment or the largest previous outstanding loan balance on any previous date of a monthly benefit payment.

"C" is the specified amount of the Policy.

The amount deducted from the monthly benefit to be applied to the loan is considered part of the monthly benefit.

Lump Sum Benefit
A lump sum benefit is offered in lieu of monthly payments. If a lump sum benefit is elected, no monthly benefits or future lump sum benefits under the corresponding option are available in the future. Similarly, if monthly payments are elected a lump sum payment for the corresponding option is not available in the future.

The lump sum benefit amounts will be determined as follows:

Lump Sum Chronic Condition Benefit
The maximum amount of the lump sum chronic condition benefit is shown in Section 1, Policy Data and cannot be more than the Maximum Accelerated Benefit Amount.

Lump Sum Confinement Benefit
The maximum amount of the lump sum confinement benefit is shown in Section 1, Policy Data and cannot be more than the Maximum Accelerated Benefit Amount.

You may elect to receive an amount less than the amounts available for the lump sum chronic condition benefit and the lump sum confinement benefit. However, we reserve the right to require that the payment be a minimum of $500.

If the Policy has an outstanding loan balance, we will deduct a portion of the lump sum benefit payment and apply this portion to reduce the loan balance. The portion deducted will equal:

$$\frac{(A \times B)}{C}$$

"A" is the lump sum benefit payment.

"B" is the value of the outstanding loan balance on the date of the lump sum benefit payment.

"C" is the specified amount of the Policy.

The amount deducted from the lump sum to be applied to the loan is considered part of the lump sum benefit.

Chronic Condition Option
If the Insured has a chronic condition, you may elect this option to provide monthly chronic condition benefits. In order to exercise this option:

1. we must receive evidence satisfactory to us that the Insured has a chronic condition, and
2. the Insured must have had the chronic condition continuously for the preceding 90 days.

If you do not wish to receive monthly payments, you may elect to receive a lump sum as described above.

Confinement Option
If the Insured is confined, you may elect this option to provide monthly confinement benefits. In order to exercise this option:

1. the Insured must be currently, and have been continuously for the preceding 90 days, confined as defined herein, and
2. the Insured's confinement must be due to medical reasons that are verified by a licensed physician.

If you do not wish to receive monthly payments, you may elect to receive a lump sum as described above.

Conditions
Your right to receive payment under either option is subject to the following conditions:

1. You must elect an option in writing and provide initial and ongoing evidence of qualification in a form that meets our requirements;
2. The Policy must be in force and not be in the grace period;
3. We must receive the approval of any assignee or irrevocable beneficiary under your Policy;
4. We have the right to seek a second medical opinion as to a Chronic Condition the Insured may have or the medical necessity for nursing home confinement. If we seek a second medical opinion, we will pay for it and will base eligibility for benefits on that opinion;
5. This benefit provides for the accelerated payment of life insurance proceeds and is not intended to cause you to involuntarily gain access to proceeds ultimately payable to the named beneficiary. Therefore, we will make the accelerated death benefit proceeds available to you on a voluntary basis only. Accordingly:
    a. if you are required by law to exercise this option to satisfy the claims of creditors, whether in bankruptcy or otherwise, you are not eligible for this benefit; or
    b. if you are required by a government agency to exercise this option in order to apply for, obtain, or retain a government benefit or entitlement, you are not eligible for this benefit.

Effect on Policy
Payments under this rider will reduce the amount payable on death, maturity or surrender of the Policy.

We will deduct the lien from values available for withdrawal or loan.

If the death benefit option on your Policy is Option B or Option C when benefits become payable, we will automatically change the death benefit option to Option A. The new Option A specified amount will be the specified amount as described in the Policy's option change provision. The Benefit Base will be increased in proportion to the increase in the specified amount, but cannot exceed the Maximum Accelerated Benefit Amount shown in Section 1, Policy Data.

After any benefit payment is made under this rider we will have an absolute first lien against the Policy for an amount equal to the sum of all benefits paid under this rider.

We will exercise the lien when:

1. benefit payments are no longer payable under this rider;
2. you have received benefit payments totaling the Maximum Accelerated Benefit Amount;
3. the Policy terminates for any reason; or
4. this rider terminates for any reason.

On the date the lien is exercised, the values in the Policy are adjusted as follows:

1. the specified amount is reduced by the amount of the lien;
2. the accumulated value is reduced by an amount equal to the lien multiplied by the ratio of the accumulated value to the specified amount of the Policy;
3. the Benefit Base is reduced by the amount of the lien; and
4. surrender charges are reduced in proportion to the reduction in the specified amount.

After the lien is exercised there will be no further lien against the Policy. When the lien is exercised while the Policy is in force, we will send you updated information reflecting the changes to the values in the Policy.

Rider Cost of Insurance

The cost of insurance for this rider is determined on a monthly basis. The cost of insurance rates for this rider will not exceed the rates shown in the Table of Guaranteed Maximum Monthly Enhanced Living Benefits Cost of Insurance Rates per $1,000, found on the last page of this rider. The cost of insurance rate multiplied by the Benefit Base divided by the specified amount of the Policy is added to the Insured's cost of insurance rate for the Policy. The

cost of insurance is then determined as provided in the Policy using the increased rates.

The cost of insurance for this rider will be deducted monthly from the accumulated value.

General Provisions

The following provisions apply to this rider:

Applicability
This rider is a part of the Policy to which it is attached, and this benefit is subject to all the provisions of this rider and the applicable Policy provisions.

Effective Date
The effective date of this rider is shown in Section 1, Policy Data. The incontestability provision in the Policy will apply to this rider, beginning on the rider effective date.

Cancellation
We may not cancel or reduce coverage under this rider. You may cancel this rider on any monthly anniversary day. Your request must be in writing and filed with us prior to the monthly anniversary day.

Conformity with State Statutes
On the effective date of this rider, if any provisions are in conflict with the laws of the state in which you reside, then these provisions are amended to conform to the minimum requirements of such laws.

Termination of Rider
This rider terminates on the earliest of:

1. the date the Policy terminates for any reason;
2. the date this rider is cancelled by you;
3. the date you have received benefit payments totaling the Maximum Accelerated Benefit Amount;
4. the date the Policy matures;
5. the date you exercise a Paid-up Insurance Benefit option, if any, in the Policy; or
6. the date no further benefit payments are available under either option.

Table of Guaranteed Maximum Monthly Enhanced Living Benefits Cost of Insurance Rates per $1,000

Age	Male	Female	Age	Male	Female	Age	Male	Female
0	0.06000	0.06583	34	0.07000	0.08750	68	0.79083	0.82667
1	0.04667	0.05917	35	0.07167	0.09000	69	0.87917	0.90500
2	0.04500	0.05667	36	0.07500	0.09500	70	0.96583	0.98917
3	0.04417	0.05500	37	0.07833	0.09917	71	1.06417	1.08000
4	0.04167	0.05417	38	0.08250	0.10417	72	1.17667	1.17917
5	0.04000	0.05250	39	0.08833	0.10917	73	1.28500	1.29167
6	0.03750	0.05083	40	0.09417	0.11583	74	1.39917	1.44500
7	0.03500	0.05000	41	0.10083	0.12167	75	1.51833	1.63667
8	0.03417	0.04917	42	0.10917	0.12750	76	1.69167	1.84917
9	0.03333	0.04833	43	0.11750	0.13333	77	1.87417	2.07750
10	0.03417	0.04833	44	0.12667	0.13750	78	2.08333	2.32583
11	0.03667	0.04917	45	0.13667	0.14500	79	2.26167	2.57167
12	0.04167	0.05167	46	0.14750	0.15333	80	2.45833	2.80917
13	0.04833	0.05417	47	0.15833	0.16250	81	2.67667	3.11083
14	0.05667	0.05833	48	0.17000	0.17417	82	2.92250	3.43667
15	0.05750	0.06083	49	0.18250	0.18583	83	3.17083	3.73250
16	0.05833	0.06333	50	0.19583	0.19917	84	3.43333	4.04333
17	0.06000	0.06583	51	0.20917	0.21250	85	3.70333	4.42167
18	0.06083	0.06583	52	0.22333	0.22667	86	4.00583	4.81167
19	0.06167	0.06667	53	0.23667	0.24167	87	4.31083	5.21333
20	0.06250	0.06750	54	0.25250	0.25583	88	4.61667	5.70417
21	0.06250	0.06833	55	0.27000	0.27167	89	4.92667	6.22250
22	0.06250	0.06917	56	0.28833	0.28833	90	5.24667	6.77083
23	0.06250	0.07083	57	0.30667	0.30750	91	5.58500	7.36250
24	0.06250	0.07250	58	0.32583	0.32833	92	5.95417	8.02083
25	0.06250	0.07417	59	0.34583	0.35417	93	6.39667	8.79500
26	0.06333	0.07583	60	0.36833	0.38250	94	6.99667	9.79833
27	0.06417	0.07667	61	0.39167	0.41667	95	7.59667	10.80583
28	0.06500	0.07833	62	0.43167	0.45583	96	8.19667	11.82167
29	0.06500	0.08000	63	0.47667	0.50250	97	8.79667	12.85000
30	0.06583	0.08167	64	0.52667	0.55500	98	9.39667	13.90333
31	0.06583	0.08250	65	0.58083	0.61500	99+	10.00000	15.00000
32	0.06667	0.08417	66	0.64833	0.68000			
33	0.06750	0.08500	67	0.72250	0.75167			

Signed for Kansas City Life Insurance Company, a stock company, at its Home Office, 3520 Broadway, PO BOX 219139, Kansas City, MO 64121-9139.

Secretary

President, CEO and Chairman

KANSAS CITY LIFE INSURANCE COMPANY
3520 Broadway, PO Box 219139
Kansas City, MO 64121-9139

ENHANCED LIVING BENEFITS RIDER
SUPPLEMENT TO APPLICATION

Name of Primary Insured _____ Application Number _____

Name of Applicant, if other than Primary Insured _____

		YES	NO
1.	Do you need assistance or supervision of any kind to perform the following activities of daily living? (Please explain "Yes" answers below.)		
	(A) eating _____	☐	☐
	(B) dressing _____	☐	☐
	(C) bathing _____	☐	☐
	(D) walking _____	☐	☐
	(E) getting in and out of bed _____	☐	☐
	(F) taking medications _____	☐	☐
	(G) using the toilet _____	☐	☐
2.	(A) What type of activities do you participate in? (hobbies, volunteer work, social activities, exercise, walking, travel, church, etc.) _____		
	(B) Do you drive?	☐	☐
3.	Do you use any medical appliances (wheelchair, walker, cane, hospital bed)? If so, please explain. _____	☐	☐
4.	During the past 24 months have you been confined, or has confinement been recommended, to a hospital, nursing home, home for the aged, or any other institution or care center?	☐	☐
5.	What type of dwelling do you live in (ranch style, duplex, apartment, retirement complex, etc.)? _____ With whom do you reside? (name/relationship) _____		
6.	Do you have a long-term care insurance policy, rider, or certificate in force (including health care service contract, health maintenance organization contract, etc.)? If so, how much, and with what company? _____	☐	☐
7.	Did you have a long-term care insurance policy, rider, or certificate in force during the last 12 months?	☐	☐
	(A) If so, with which company? _____		
	(B) If that policy lapsed, when did it lapse? _____		
	(C) Are you covered by a state assistance program (Medicaid)?	☐	☐
	(D) Do you intend to replace any of your medical or health insurance coverage with this policy, rider or certificate?	☐	☐

Agreement and Signatures

Benefits paid under this rider may be taxable. If so, you or your beneficiary may incur a tax obligation. As with all tax matters, you should consult your personal tax advisor to assess the impact of this benefit.

It is understood and agreed that the statements and answers recorded in this supplement to the application are, to the best of my (our) knowledge and belief, true and complete. I (we) understand that if my (our) answers on any part of the application are incorrect or untrue, Kansas City Life may have the right to deny benefits or rescind the policy. I (we) understand this supplement to the application will become a part of any policy issued on it.

Dated at _____ this _____ day of _____, 20_____ .

_____ | _____
Agent's Code | Primary Insured's Signature

_____ | _____
Agency Code | Applicant's Signature (if other than Primary Insured)

Agent Information Statement

	YES	NO
1. List any health insurance policies that you have sold to the applicant.		
_____		
(A) List such policies that are still in force.		
_____		
(B) List such policies sold in the past five years that are no longer in force.		
_____		
2. Did you personally interview the proposed insured, face to face, and witness his/her signature?	☐	☐
3. Did you observe any physical impairments with regard to walking, talking, or any form of tremor?	☐	☐
4. Did you observe any disorientation as to time, place, or space, or did the applicant show any signs of confusion?	☐	☐

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Consumer Info Compliance.pdf
Regulation 19 Cert.pdf
Regulation 49 Cert.pdf
Readability Certification.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

This application will be used with the Supplement to Application that is attached to the Forms Schedule Tab.

Attachment:

A160-AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Disclosures

Comments:

Attachments:

M686.pdf
M687.pdf

Item Status: **Status Date:**

Satisfied - Item: Sample Schedule Page

Comments:

This schedule page will be issued with the policy when the rider is elected.

Attachments:

ContractData R223.pdf

SERFF Tracking Number:	*KCLF-127814876*	*State:*	*Arkansas*
Filing Company:	*Kansas City Life Insurance Company*	*State Tracking Number:*	*50335*
Company Tracking Number:	*R223*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*R223*		
Project Name/Number:	*R223/R223*		

ContractData R224.pdf

Item Status: **Status Date:**

Satisfied - Item: Actuarial Memorandum
Comments:
Attachment:
Actuarial Memorandum.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability
Comments:
Attachment:
Statement of Variability.pdf

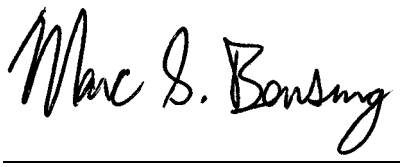
STATE OF ARKANSAS
Consumer Information Notice
COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Enhanced Living Benefits Rider
Enhanced Living Benefits Rider
Enhanced Living Benefits Rider Supplement to Application

FORM NUMBER(S): R223, R224 and A165

I hereby certify that to the best of my knowledge and belief, the above forms and submissions are in compliance with ACA 23-79-138 and Bulletin 11-88, as well as the other laws, rules and regulations of the State of Arkansas.



Marc Bensing
Assistant Vice President
Kansas City Life Insurance Company

November 23, 2011

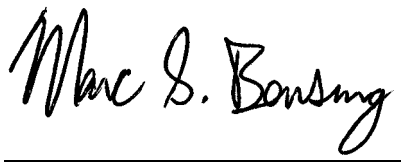
STATE OF ARKANSAS
COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Enhanced Living Benefits Rider
Enhanced Living Benefits Rider
Enhanced Living Benefits Rider Supplement to Application

FORM NUMBER(S): R223, R224 and A156

I hereby certify that to the best of my knowledge and belief, the above form and submission is in compliance with Regulation 19, as will as the other laws, rules and regulations of the State of Arkansas.



Marc Bensing
Assistant Vice President
Kansas City Life Insurance Company

Date: November 23, 2011

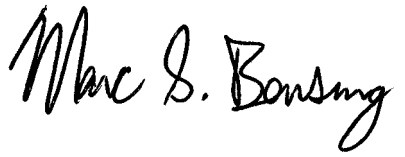
STATE OF ARKANSAS
COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Enhanced Living Benefits Rider
Enhanced Living Benefits Rider
Enhanced Living Benefits Rider Supplement to Application

FORM NUMBER(S): R223, R224 and A165

I hereby certify that to the best of my knowledge and belief, the above form and submission is in compliance with Regulation 49, as will as the other laws, rules and regulations of the State of Arkansas.

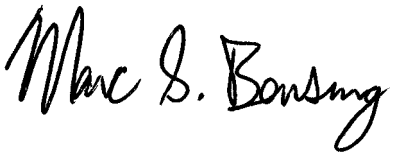


Marc Bensing
Assistant Vice President
Kansas City Life Insurance Company

Date: November 23, 2011

READABILITY CERTIFICATION

Form	Score
R223	50.4
R224	50.4
A165	60.8



Name: Marc S. Bensing

Title: Assistant Vice President

Company: Kansas City Life Insurance Company

Date: November 21, 2011

KANSAS CITY LIFE INSURANCE COMPANY

Application for Life Insurance

PERSONAL DATA

Proposed Insured Information

Full Name _____ (First / Middle / Last) ☐ Male ☐ Female Date of Birth ____/____/____ (Month / Day / Year)

☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

State of Birth _____ SSN _____

Former Full Name _____ (First / Middle / Last)

Street Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cellular Phone (____) _____

E-Mail Address _____ Driver's License No. _____ State of Issue _____

Employer _____ Street Address _____

City _____ State _____ Zip _____

Occupation and Duties _____ Years Employed _____

If you have been employed at your current position less than **two** years, complete the following:

Former Employer _____ Occupation and Duties _____

Ownership Information

(The Insured will be the Owner unless otherwise stated.)

Primary Owner _____ (First / Middle / Last) ☐ Male ☐ Female Date of Birth ____/____/____ (Month / Day / Year)

State of Birth _____ SSN or Tax ID _____ Relationship to Insured _____

Street Address _____ City _____ State _____ Zip _____

Successor Owner _____ Relationship to Insured _____

(If there are multiple Successor Owners, show order and distribution in Special Requests.)

Applicant Information

(Complete the following information if the applicant is someone other than the Insured or the Owner.)

Applicant _____ (First / Middle / Last) ☐ Male ☐ Female Relationship to Insured _____

Street Address _____ City _____ State _____ Zip _____

Beneficiary Information* (with right to change)

Primary Beneficiary (First and Last Name) — Relationship to Insured

_____ _____

_____ _____

Contingent Beneficiary (First and Last Name) — Relationship to Insured

_____ _____

_____ _____

*Unless otherwise stated, benefits are payable equally to the named beneficiaries or to the surviving beneficiaries.

Special Requests (Policy date, alternate or additional policy, existing PAC or CB number, etc.) **Home Office Endorsements**

PLAN DATA

Life Insurance

Plan Name _____ Specified/Face Amount $ _____ UL Coverage Option ☐ A ☐B ☐ C (if available)

Planned/Annual Premium $ _____ DEFRA Compliance ☐ Guideline Premium Test (GLP) ☐ Cash Value Accumulation Test (CVAT)

Special Class Premium $ _____ Reason for Special Class Premium _____

Proposed Risk Class _____ Automatic Premium Loan ☐ Yes ☐ No

Riders/Benefits

☐ Accidental Death $ _____
☐ Assured Insurability $ _____
☐ Charitable Giving (Term)
☐ Children's Term _____ units
☐ Spouse's Term _____ units
☐ Waiver of Premium (Non-UL)
☐ Other _____

UL Only:
☐ Additional Life Insurance $ _____
☐ Cost of Living
☐ Disability Payment of Premium $_____
☐ Extra Protection $ _____
☐ Other Insured (complete information below)

UL Only:
☐ Automatic Growth
☐ Disability Continuance of Insurance
☐ Enhanced Living Benefits
☐ Living Benefits
☐ Monthly Benefit $_____
☐ Pension Increase
☐ Terminal Illness

Other Insureds (OI)

	Full Name (First, Middle, Last)		Marital Status	Specified Amount	
1st OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
2nd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
3rd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
4th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
5th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____

Complete the following for all Other Insureds. If years employed is less than **two years**, specify the prior occupation in Special Requests. If any information is identical to the Primary Insured's, write **Same.**

	Social Security Number	State of Birth	Occupations and Exact Duties	Employer's Name and Address	Years Emp.
1st OI	_____	_____	_____	_____	_____
2nd OI	_____	_____	_____	_____	_____
3rd OI	_____	_____	_____	_____	_____
4th OI	_____	_____	_____	_____	_____
5th OI	_____	_____	_____	_____	_____

	Street Address, City, State, Zip	Telephone Number	Driver's License Number and State of Issue
1st OI	_____	(____) _____ ☐home ☐work	_____
2nd OI	_____	(____) _____ ☐home ☐work	_____
3rd OI	_____	(____) _____ ☐home ☐work	_____
4th OI	_____	(____) _____ ☐home ☐work	_____
5th OI	_____	(____) _____ ☐home ☐work	_____

BILLING INFORMATION

Premium Mode ☐ Ann ☐ SA ☐ Qtly ☐ Mo ☐* EPA ☐ GA ☐ CB ☐ FAP ☐ Single ☐ Other _____

* ☐ I request Kansas City Life to withdraw the **initial** monthly premium from my checking account to pay the premium on this policy. **(The initial draft will be drafted immediately on approval for a standard or better rate class. The Temporary Life Insurance Agreement, A133, is required.)**

Premium Notices Delivered To: ☐ Owner ☐ Primary Insured
☐ Other (provide name and address) _____

Modal Premium Amount for Other Financial Services $_____

Branch of Service for GA _____

Payor's SSN for Government Allotment _____

REPLACEMENT

1) Will any existing life or annuity contract be lapsed, reissued, surrendered, or converted (to reduce amount, premium, or period of coverage, including surrender options) if the proposed policy is issued? ..... ☐ Yes ☐ No
2) Will the proposed policy be financed by loans from this or any other policy or annuity? ..... ☐ Yes ☐ No
If **Yes**, provide name of company(ies) or amount(s) _____
3) Will the proposed policy be part of an Internal Revenue Code Section 1035 Exchange? ..... ☐ Yes ☐ No

EVIDENCE OF INSURABILITY

Insurance History

Do any of the proposed Insureds currently have life insurance coverage? ..... ☐ Yes ☐ No
(If **Yes**, fill out the table below; if **No**, proceed to question 1 directly below the table.)

Proposed Insured(s)	Company	Year Issued	Insurance Amount	ADB Amount
			$	$
			$	$
			$	$
			$	$

1) In the **last three years,** have any of the proposed Insureds applied for life or health insurance or reinstatement thereof without receiving it exactly as requested? ..... ☐ Yes ☐ No
2) Do any of the proposed Insureds have an application for life or health insurance pending at any other insurance company or intend to apply for such insurance within the next 10 days? ..... ☐ Yes ☐ No

Provide details to all **Yes** answers. _____

FINANCIAL INFORMATION

Complete For Personal Insurance Sales

Purpose of insurance (Check all that apply) ☐ Family Income Protection ☐ Mortgage Protection ☐ Estate Planning ☐ Retirement Savings ☐ College Savings ☐ Final Expenses ☐ Other _____

Annual earned income (Include Salary, Bonus, Commissions)

☐ Proposed Insured $_____ ☐ Other Insured $_____

☐ Spouse $_____ ☐ Family net worth $_____
(Total assets minus total liabilities)

Has(Have) the proposed Insured(s) ever filed for bankruptcy? ☐ Yes ☐ No

If **Yes**, please provide type (Chapter ☐ 7, ☐11, ☐13) and date closed. _____

Spouse's Occupation _____ Amount of life insurance in force on Spouse $_____

Complete For Business Insurance Sales

Purpose of insurance (Check all that apply) ☐ Key Person ☐ Deferred Compensation ☐ Buy/Sell ☐ Creditor ☐ Other _____

For the option(s) checked, how was the amount of insurance determined? _____
(Please provide documentation)

Annual earned income of proposed Insured $_____ Proposed Insured's ownership of company _____%

Are other owners, officers, or key persons being insured? ☐ Yes ☐ No If **No**, please explain. _____

Total assets of company $_____ Total liabilities of company $_____

Net worth of company $_____ Net income of company after taxes last fiscal year $_____

Has company ever filed bankruptcy? ☐ Yes ☐ No If **Yes**, please provide type (Chapter ☐7, ☐11, ☐13) and date closed._____

NON-MEDICAL UNDERWRITING QUESTIONS

Questions apply to all proposed Insureds*

1) Do any of the family members listed on this application live outside the Primary Insured's household?..... ☐ Yes ☐ No

2) Are any proposed Insureds not a U.S. citizen? ..... ☐ Yes ☐ No
If **Yes**, how long has(have) the proposed Insured(s) been in the United States?_____
Visa type?_____ Visa number? _____

3) Have any of the proposed Insureds in the last 12 months, or do any of the proposed Insureds within the next 24 months, intend to travel or reside outside the continental U.S. or Canada? If **Yes**, explain below. ..... ☐ Yes ☐ No

4) In the **last three years**, has any proposed Insured:
   a) been cited or convicted for any moving motor vehicle violations? If **Yes**, explain below. ..... ☐ Yes ☐ No
   b) had a driver's license suspended or revoked? If **Yes**, explain below. ..... ☐ Yes ☐ No
   c) flown as a pilot, co-pilot, or crew member of an aircraft? If **Yes**, complete the Aviation Questionnaire. ..... ☐ Yes ☐ No
   d) engaged in sky or scuba diving, hang gliding, racing or any other hazardous sport or hobby? If **Yes**, complete the Avocations Questionnaire. ..... ☐ Yes ☐ No

5) Has any proposed Insured ever been convicted of a felony? If **Yes**, explain below. ..... ☐ Yes ☐ No

6) For proposed Insured **(a)** and Other Insureds **(b)**, is there any **family history** of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, suicide, or stroke? If **Yes**, explain below..... ☐ Yes ☐ No

Relationship	Age if Living **(a)**	**(b)**	Family History or Cause of Death	Age at Death **(a)**	**(b)**
Father					
Mother					
Brothers and Sisters					

*****Provide details to all **Yes** answers. _____

JUVENILE INSURANCE (AGE 0-17)

1) If any proposed Insured(s) is(are) less than one year old, what was birth weight? (name and birth weight) _____

2) If any proposed Insured(s) is(are) age 5-15, what is grade in school? (name and grade) _____

3) Are all children insured equally? ☐ Yes ☐ No If **No**, please explain. _____

4) Amount of insurance in force on father $_____

5) Amount of insurance in force on mother $_____

HEALTH STATEMENT

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in the Past Year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1) Primary Insured	X	X	X	X	X	X					
2)											
3)											
4)											
5)											
6)											

Questions apply to all proposed Insureds*

	YES	NO
1) Do you take prescription medicine?		
2) Are you currently pregnant? Due date? _____		
3) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or for the use of drugs except for medicinal purposes, or received treatment or advice from an organization that assists those who have an alcohol or drug problem?		
4) Have you used any form of nicotine/tobacco in the last 12 months (e.g. cigar, pipe, smokeless tobacco, cigarettes, etc.)? If cigarettes, how many packs per day? _____		
5) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?		
6) During the last five years, have you been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?		
In the last 10 years, have you been diagnosed or treated for any disease or disorder of:		
7) Brain and nervous system: Mental illness, epilepsy, seizures, stroke, paralysis?		
8) Sight or hearing?		
9) Blood: anemia or leukemia?		
10) Tumor or cancer?		
11) Heart/blood vessels: murmur, chest pain or pressure, palpitations, heart attack?		
12) Blood pressure?		
13) Thyroid or glandular trouble?		
14) Lungs: asthma, emphysema, tuberculosis?		
15) Digestive system: ulcer, intestines or rectum, polyps, colitis?		
16) Liver: elevated enzymes, cirrhosis, hepatitis?		
17) Diabetes, sugar in urine?		
18) Kidney, bladder or prostate: albumin, blood, or pus in urine?		
19) Muscles, bones, or joints (e.g. arthritis)?		
20) Breasts, uterus, or ovaries?		
21) Menstruation or pregnancy?		
Have you ever been diagnosed or treated for:		
22) A sexually transmitted disease?		
23) Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive?		

*Provide details to all **Yes** answers. Identify proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

Names, addresses, and phone numbers of personal or family physicians. (If none, list last physician, clinic, or hospital consulted.)

Date and Reason Last Consulted

Clinic or VA Claim Number

Civilian Aviation Questionnaire

Name of proposed Insured _____

As a pilot or student pilot, indicate the number of hours flown in command _____ Date of last flight _____

Type of license currently held ☐ Commercial ☐ Student ☐ Private

Do you hold a valid instrument rating? ☐ Yes ☐ No

Number of hours flown in the last 12 months _____

Number of hours flown in the last 12-24 months _____

Number of flying hours contemplated in next 12 months _____

Purpose of present and future flying
☐ Pleasure ☐ Personal Business
☐ Commercial ☐ Other (specify) _____

Type and class of aircraft flown
☐ Propeller ☐ Glider ☐ Home-Built
☐ Jet ☐ Balloon ☐ Ultralite
☐ Helicopter ☐ Hang Glider

Do you expect to engage in any of the following types of flying within the next 12 months? If **Yes**, state which and number of hours.

	Hours		Hours
☐ Scheduled Airlines	_____	☐ Pipeline Inspection	_____
☐ Nonscheduled Airlines	_____	☐ Air Taxi or Sight Seeing	_____
☐ Employer Owned Aircraft	_____	☐ Photography	_____
☐ Crop Dusting	_____	☐ Mapping	_____
☐ Water Bombing	_____	☐ Test or Inspection Flying	_____
☐ Student Instruction	_____	☐ Aerobatics	_____
☐ Charter Flying	_____	☐ Racing	_____
☐ Freight or Mail Carrying	_____	☐ Any Other for Pay Flying	_____ Type _____

Have you ever:

a) been in an aircraft accident? ☐ Yes ☐ No If **Yes** to a, b, or c, explain below in Additional Details.

b) been grounded? ☐ Yes ☐ No

c) been fined or reprimanded? ☐ Yes ☐ No

Do you have any operational limitations on your medical certificate? ☐ Yes ☐ No If **Yes**, explain below in Additional Details.

Do you contemplate flying in Alaska? ☐ Yes ☐ No

Do you contemplate flying outside the continental United States? ☐ Yes ☐ No If **Yes**, explain below in Additional Details.

If aviation required an extra premium or exclusion rider, which would you prefer? ☐ Extra Premium ☐ Exclusion Rider

Additional Details

Avocations Questionnaire

Name of proposed Insured _____

UNDERWATER DIVING

	Average Depth	Average Time (minutes)	Last 12 Months	1 to 2 Years Ago	Estimated Next 12 Months
	0-65 ft.				
	66-100 ft.				
	101-150 ft.				
	Over 150 ft.				

Frequency (Days)_____

Type ☐ Scuba ☐ Skin or snorkel

Purpose

☐ Recreation ☐ Wreck/Salvage/Retrieval ☐ Commercial

☐ Search/Rescue ☐ Instructor ☐ Other _____

Certification (Check highest certificate attained.)

☐ Basic ☐ Open-Water ☐ Advanced Open Water ☐ Dive Master/Instructor ☐ No Certificate

Locations

☐ Lakes ☐ Rivers ☐ Oceans

☐ Quarries ☐ Pools ☐ Other _____

Do you use the "buddy system"? ☐ Yes ☐ No Do you engage in ice diving? ☐ Yes ☐ No

Do you engage in cave diving? ☐ Yes ☐ No Date of last dive _____

PARACHUTING OR SKYDIVING

☐ Amateur
☐ Professional

Association or club member ☐ Yes ☐ No

Number of years _____ Date of last jump _____ Average number of jumps per year _____

Do you compete for record attempts? ☐ Yes ☐ No Do you use experimental equipment? ☐ Yes ☐ No

AUTOMOBILE RACING

Type of vehicle used in races? _____ What is the maximum speed attained? _____ What is the average speed attained? _____

Purposes of racing ☐ Amateur ☐ Professional ☐ Both (provide details) _____

How many races did you enter in the last 12 months? _____ How many races did you enter in the last 13-24 months? _____ How many races do you contemplate in the next 12 months? _____

☐ Championship (Indy Cars)

☐ Demolition

☐ Drag Racing (Circle those that apply: Funny Car, Top Fuel, Pro Stock, Modified Production, Modified Super Stock, Pure Stock)

☐ Formula Racing (Circle those that apply: Formula One, Supervee, Vee, Ford)

☐ Midget Car Racing

☐ Sports Car Racing (Circle those that apply: CanAm, TransAm, Production, A, B, C, All American GT, Showroom Stock, Vintage Sports)

☐ Stock Car (Circle those that apply: NASCAR Winston Cup Division, Winston Division, NASCAR Busch Grand National Division, NASCAR Modified Division, USAC Super Modified Division, Amateur, Street Stock, Hobby Division)

☐ Racing not covered above (provide type and details). _____

_____

OTHER AVOCATIONS

(Please provide details in Remarks section.)

☐ Ballooning ☐ Mountain or Rock Climbing ☐ Bungee Jumping

☐ Hang Gliding ☐ Motorboat or Powerboat Racing ☐ White Water Rafting

☐ Ultralite Flying ☐ Motorcycle Racing ☐ Other

Remarks

Military Questionnaire

Name of proposed Insured _____

Permanent Address (non-military residence) _____

STATUS

Branch of Service _____

Date entered active service _____ Present pay grade _____

Name and location of present unit _____

Have you or your unit been alerted for overseas assignment? ☐ Yes ☐ No

If **Yes**, where? _____

Usual duty assignment (e.g., Tank Mechanic, Cook, Radar Operator, etc.) _____

Do you qualify for hazardous duty pay? ☐ Yes ☐ No

If **Yes**, why? (e.g., flying duty, submarine duty, etc.). _____

Have you any reason to believe you will, within the next 90 days, be transferred or have you any knowledge of any change in activities? ☐ Yes ☐ No

If **Yes**, provide details _____

MILITARY AVIATION

How many total hours have you accumulated as a pilot or as a crew member? _____

Hours estimated in the next 12 months as a pilot or as a crew member? _____

Job title _____ Aviation activity and duties _____

Do you fly for proficiency only? ☐ Yes ☐ No

If **Yes**, specify hours flown and provide full details _____

Duty assignment (MAC, SAC, TAC, etc.) _____

Aircraft in which duties are performed (F4, B52, T28, HO-1, etc.) _____

Agreement

It is understood and agreed as follows:

1) The statements and answers recorded in all parts of this application are true and complete.
2) No information regarding any proposed Insured will be considered known by the Company unless explicitly set out in writing on this application.
3) This application and the answers to any required medical exam will become a part of any policy issued on it.
4) No agent has the authority to waive any of the Company's rights or rules or to make or change any contract.
5) The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to the applicant; and (2) the first full premium is paid in cash. The only exception to this is provided in the Temporary Life Insurance Agreement if the agreement has been issued and the advance payment required by the agreement has been made.
6) Any changes or additions made by the Company in "Home Office Endorsements" will be ratified by the applicant's acceptance of any life insurance policy issued on this application. However, any change in the classification, amount of insurance, issue age, plan of insurance or any benefits will not be effective unless accepted in writing by me(us).
7) I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
8) I(We) have paid $_____* to the agent in exchange for the Temporary Life Insurance Agreement and I(we) acknowledge that I(we) fully understand and accept its terms.

***All premium checks must be made payable to Kansas City Life Insurance Company. Do not make the check payable to the agent or leave the payee blank.**

(Continued on next page)

(Continued from previous page)

Authorization for the Release of Medical Information
To obtain a copy of or to revoke this authorization, contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

This authorization applies to all persons whose signatures appear below. The proposed Primary Insured and all other proposed Insureds must sign.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Kansas City Life Insurance Company or any person acting on behalf of Kansas City Life Insurance Company. "Information" means facts regarding my physical or mental condition (including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; mental illness; the use of alcohol, drugs, and tobacco; but excluding psychotherapy notes); employment; other insurance coverage; financial status; or any other relevant information about me or my minor children. Information obtained will be released only to reinsurers; MIB, Inc.; persons and entities performing business duties as delegated or contracted for by Kansas City Life Insurance Company related to my application and subsequent insurance-related functions as permitted or required by law or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Kansas City Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Kansas City Life Insurance Company.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that Kansas City Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Kansas City Life Insurance Company may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ day of _____, 20_____.
City/State **Month** **Year**

_____ _____
Primary Insured's Signature (if under 15, parent/guardian signature) **Applicant's Signature (if other than Primary Insured)**

_____ _____
Spouse's Signature (if spouse coverage applied for) **First Other Insured's Signature (if over age 18)**

_____ _____
Second Other Insured's Signature (if over age 18) **Third Other Insured's Signature (if over age 18)**

_____ _____
Fourth Other Insured's Signature (if over age 18) **Fifth Other Insured's Signature (if over age 18)**

Statement of Agent

I certify that the statements of the Primary Insured, applicant and any other proposed Insured(s) have been correctly recorded in this application and that any premium payment shown in item 8 under Agreement on page 9 has been collected by me and that a Temporary Life Insurance Agreement has been given to the applicant.

To the best of my knowledge, the insurance applied for in this application ☐ will ☐ will not replace existing insurance.

Did you see all proposed Insureds at the time of application? ☐ Yes ☐ No (If **No**, an examination may be required.)

Agent Code	**Signature of Writing Agent**
Agency Code	**Agency**

Agent Code	**Signature of Other Agent(s) (if split case)**

KANSAS CITY LIFE INSURANCE COMPANY

Pre-Authorized Check Plan (PAC)

PAC Instructions

1) This form is to be used to request the establishment of a new PAC plan or change banks or accounts under an existing PAC plan. Do not use this form to add a policy to an existing PAC plan. Instead, simply provide the existing PAC plan number in the Special Requests section of the application.
2) **Attach a personalized sample check from the account to be used.**
3) The total monthly premium on all policies in a PAC plan must be at least $10.

Request for PAC: I request Kansas City Life Insurance Company to make monthly withdrawals from my checking account to pay premiums on this policy applied for or to make monthly withdrawals from my checking account to pay premiums on the following additional pending applications. (Include name of proposed Insured(s) and policy number if available.)_____

Draft Date: I request Kansas City Life Insurance Company to draw the PAC check or debit entry on or after the _____***** day of the month.
***** Available draft days are the 1st through the 28th.

Account Information

Payor's Name_____

Bank Name_____ Branch Name (if any)_____

☐ Checking ☐ Savings Account Number_____Bank Transit Number_____

Bank's Address where Account is Maintained _____
Street **City** **State** **Zip**

Agreement for Automatic Premium Payments and Authorization to Honor Checks Drawn by the Company

It is agreed that:

1) This PAC plan does not change any policy provisions. The payor's authorization is not in lieu of payment in cash of the first premium and does not constitute advance payment required by the Temporary Life Insurance Agreement.
2) Upon 30 days written notice, this PAC plan may be stopped or changed at any time by: the owner of any policy under this PAC plan, the Company, or the payor.
3) Withdrawals will be made on or about the premium draft date shown above.
4) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
5) The privilege of paying premiums under this PAC plan may be revoked by the Company if any check or debit entry is not paid upon presentation.
6) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
7) If any debit or check entry is dishonored, the Company will be under no liability whatsoever, even if such dishonor results in forfeiture of insurance.
8) I authorize the Company to pay and charge to my(our) account, debit entries or checks drawn by and payable to the order of the Company, provided there are sufficient collected funds present to pay same upon presentation. This authorization will remain in effect until revoked by me in writing, a copy of which will be sent to the Company. Until the Company receives such notice, I agree that the Company will be fully protected in honoring any such debit.

Date_____ Signature of Premium Payor _____

KANSAS CITY LIFE INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-7073.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Kansas City Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Kansas City Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

KANSAS CITY LIFE INSURANCE COMPANY
P. O. Box 219139 / Kansas City, MO 64121-9139

Application No. _____

Policy No. _____

How the Enhanced Living Benefits Rider Works:

The Owner may request a prepayment of a portion of the death proceeds in either monthly payments or as a lump sum. The sum of all payments may never exceed the Benefit Base. The Insured may be eligible for this benefit if diagnosed with a chronic condition and/or must be confined. Both conditions are defined in the rider and the condition must exist continuously for 90 days to make a claim. If a lump sum benefit is elected, no monthly benefits or future lump sum benefits under the corresponding option are available in the future.

Accelerated benefit payments under this rider will cause the specified amount of the Contract to be reduced. The minimum accelerated benefit under this rider is $50 per month or $500 for a lump sum. The maximum accelerated benefit is stated in Section 1 of the Contract. In no case will any combination of benefits paid for chronic condition or confinement exceed 100% of the maximum accelerated benefit. The maximum total accelerated death benefits payable by us under all policies or riders on the life of a single insured can never exceed $500,000 regardless of the number or sizes of the policies or riders in force.

A permanent lien will be placed on the Contract when monthly or lump sum benefits are paid. The permanent lien amount will equal the total benefits paid under this rider. If the permanent lien equals 100% of the Benefit Base, the rider will terminate.

When the rider or Contract terminates for any reason, the Contract will be adjusted as follows:

1. The new specified amount will equal the old specified amount less the permanent lien.
2. The Contract value will equal the new specified amount times the Contract value on the adjustment date divided by the old specified amount.

	Example #1	**Example #2**
Specified Amount	$250,000	$1,000,000
Benefit Base	$200,000	$350,000
Payment Amount	$2,000	$35,000
Claim Type	Monthly	Lump Sum
Payment period	100 months	One time
Lien Amount	$200,000	$35,000
Unadjusted Accumulated Value	$90,000	$315,000
Unadjusted Loan Balance	$10,000	$0
Adjusted Benefit Base	$0	$315,000
Adjusted Specified Amount	$50,000	$965,000
Adjusted Accumulated Value	$18,000	$303,975
Adjusted Loan Balance	$2,000	$0

THE ACCELERATED BENEFIT IN THIS LIFE INSURANCE PRODUCT MAY PROVIDE BENEFITS TO PAY FOR LONG-TERM CARE SERVICES, BUT IT IS NOT PART OF A LONG-TERM CARE OR NURSING HOME INSURANCE POLICY AND THE AMOUNT THIS PRODUCT PAYS YOU MAY NOT BE ENOUGH TO COVER YOUR MEDICAL, NURSING HOME OR OTHER BILLS. UNLIKE CONVENTIONAL LIFE INSURANCE PROCEEDS, ACCELERATED BENEFITS PAYABLE UNDER THIS RIDER COULD BE TAXABLE IN SOME CIRCUMSTANCES. WE RECOMMEND THAT YOU CONTACT A TAX ADVISOR WHEN MAKING TAX-RELATED DECISIONS ABOUT ELECTING TO RECEIVE AND USE BENEFITS FROM AN ACCELERATED BENEFIT PRODUCT.

RECEIPT OF ACCELERATED BENEFITS MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. THE MERE FACT THAT YOU OWN A POLICY WITH AN ACCELERATED BENEFIT PRODUCT MAY AFFECT YOUR ELIGIBILITY FOR THESE GOVERNMENT PROGRAMS. IN ADDITION, EXERCISING THE OPTION TO ACCELERATE DEATH BENEFITS AND RECEIVING THOSE BENEFITS BEFORE YOU APPLY FOR THESE PROGRAMS, OR WHILE YOU ARE RECEIVING GOVERNMENT BENEFITS, MAY AFFECT YOUR INITIAL OR CONTINUED ELIGIBILITY. CONTACT THE MEDICAID UNIT OF YOUR LOCAL DIVISION OF MEDICAL ASSISTANCE AND THE SOCIAL SECURITY ADMINISTRATION FOR MORE INFORMATION.

I request that the Acceleration of Death Proceeds Rider be issued with my Contract.

Signature of Owner	Date	Signature of Proposed Insured (if other than owner)	Date

Licensed KCL Agent	Agent Code

Instructions to Agent
Original must be given to applicant no later than at the time of application.

KANSAS CITY LIFE INSURANCE COMPANY
P. O. Box 219139 / Kansas City, MO 64121-9139

Application No. _____

Policy No. _____

How the Enhanced Living Benefits Rider Works:

The Owner may request a prepayment of a portion of the death proceeds in either monthly payments or as a lump sum. The sum of all payments may never exceed the Benefit Base. The Insured may be eligible for this benefit if diagnosed with a chronic condition and/or confinement. Both conditions are defined in the rider and the condition must exist continuously for 90 days to make a claim. If a lump sum benefit is elected, no monthly benefits or future lump sum benefits under the corresponding option are available in the future.

Accelerated benefit payments under this rider will cause the specified amount of the Policy to be reduced. The minimum accelerated benefit under this rider is $50 per month or $500 for a lump sum. The maximum accelerated benefit is stated in Section 1 of the policy. In no case will any combination of benefits paid for chronic condition or confinement exceed 100% of the maximum accelerated benefit. The maximum total accelerated death benefits payable by us under all policies or riders on the life of a single insured can never exceed $500,000 regardless of the number or sizes of the policies or riders in force.

A permanent lien will be placed on the Policy when monthly or lump sum benefits are paid. The permanent lien amount will equal the total benefits paid under this rider. If the permanent lien equals 100% of the Benefit Base, the rider will terminate.

When the rider or Policy terminates for any reason, the Policy will be adjusted as follows:

1. The new specified amount will equal the old specified amount less the permanent lien.
2. The Policy accumulated cash value will equal the new specified amount times the Policy accumulated cash value on the adjustment date divided by the old specified amount.

	Example #1	**Example #2**
Specified Amount	$250,000	$1,000,000
Benefit Base	$200,000	$350,000
Payment Amount	$2,000	$35,000
Claim Type	Monthly	Lump Sum
Payment period	100 months	One time
Lien Amount	$200,000	$35,000
Unadjusted Accumulated Value	$90,000	$315,000
Unadjusted Loan Balance	$10,000	$0
Adjusted Benefit Base	$0	$315,000
Adjusted Specified Amount	$50,000	$965,000
Adjusted Accumulated Value	$18,000	$303,975
Adjusted Loan Balance	$2,000	$0

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I request that the Acceleration of Death Proceeds Rider be issued with my Policy.

Signature of Owner	Date	Signature of Proposed Insured (if other than owner)	Date

Licensed KCL Agent	Agent Code

Instructions to Agent
Original must be given to applicant no later than at the time of application.

SECTION 1: CONTRACT DATA (CONTINUED) DATE PREPARED: 01/01/2012

INSURED
John Doe

CONTRACT NUMBER
9999999

Enhanced Living Benefits Rider

Rider Effective Date: 01/01/2012

Benefit Base	Chronic Condition Option Maximum Benefit	Confinement Option Maximum Benefit
$[90,000]	Monthly: $ [900] Lump Sum: $ [9,000]	Monthly: $ [900] Lump Sum: $ [9,000]

The Maximum Accelerated Benefit Amount is the least of the Benefit Base, [90%] of the specified amount of the Contract, and $[500,000].

SECTION 1: POLICY DATA (CONTINUED) DATE PREPARED: 01/01/2012

INSURED
John Doe

POLICY NUMBER
9999999

Enhanced Living Benefits Rider

Rider Effective Date: 01/01/2012

Benefit Base	Chronic Condition Option Maximum Benefit	Confinement Option Maximum Benefit
$[90,000]	Monthly: $ [900] Lump Sum: $ [9,000]	Monthly: $ [900] Lump Sum: $ [9,000]

The Maximum Accelerated Benefit Amount is the least of the Benefit Base, [90%] of the specified amount of the Policy, and $[500,000].

Statement of Variability:

Form R223 and R224:

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

The Benefit Base cannot ever exceed the lesser of 80% - 100% of the specified amount of the Contract (Policy) and $250,000 - $750,000

Schedule Page:

The Maximum Accelerated Benefit Amount 80% - 100% of the specified amount of the Contract (Policy) and $250,000 - $750,000

Benefit Base

Calculated amount based on the specified amount up to the maximum accelerated benefit amount

Chronic Condition Option and Confinement option Maximum Benefit Amount

Calculated based on the Benefit Base selected